

Case Number:	CM13-0035851		
Date Assigned:	12/13/2013	Date of Injury:	08/09/2013
Decision Date:	02/20/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The Claimant is a 23-year-old male with a date of injury on August 9, 2013. He slipped and fell at work. He hit his head on an IV (intravenous) pole. He was complaining of headaches and low back pain after he slipped and fell at work. He hit his head against an IV pole. A CT scan of the head was negative. Lumbar x-rays were negative. There was no loss of consciousness. He has persistent headaches and a tight sensation throughout his entire spine. He has been performing physical therapy with some benefit. There were visit notes dated August 12, August 19, and August 26, in August 28, 2013. He received physical therapy during that time. On the most recent exam, Biofreeze, hydrocodone, and Naprosyn were prescribed. He has limitation of motion and spasm, but he does not say where. There was no numbness, tingling, vertigo, or dizziness. There was no anxiety, depression, irritability or mood swings. The examination of the cervical spine found limited range of motion with a negative Spurling maneuver. Sensation was normal. There is no evidence of deformity in the upper extremities. In the lumbar spine he is able to tiptoe and heel walk without support. He has limited neck extension and flexion was adequate. Straight leg raise causes low back and leg pain. Sensation was normal. The spinal x-rays are unremarkable in the cervical and thoracic spine. Therapy was ordered twice a week for another 4 weeks. He was diagnosed with a cervical intervertebral disc syndrome, thoracic sprain/strain, lumbar intervertebral disc syndrome, lumbar radiculopathy, post-concussion syndrome, tinnitus, dizziness, headaches, myofascial pain syndrome, stress, anxiety and insomnia. In the handwritten notes dated September 12, 2013 from a chiropractor, [REDACTED]. He indicated the claimant was complaining of head, neck, and back pain with stress, anxiety and insomnia. The handwritten note was minimal. He stated there was limited and painful range of motion of the entire spine with a positive s

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Physiotherapy Cervical/Thoracic/Lumbar 2x6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

Decision rationale: The Physician Reviewer's decision rationale: The patient had received a course of physical therapy and subsequent evaluation documented no benefit or evidence of functional improvement. CA-MTUS (Effective July 18, 2009) Chronic Pain Medical Treatment guideline, section of Physical Medicine, Page 99 allows for fading of treatment (from up to 3 visits per week to 1 or less), plus active self-directed home Physician Medicine. The number of requested visits of physical therapy in addition to the previous therapy sessions is in excess of the recommendation of the referenced guidelines. Moreover, evidence that a home exercise program could not adequately address the current issues experienced by the patient is not noted. Therefore the request for 12 physical therapy sessions is not medically necessary

Transcutaneous electrical nerve stimulation (TENS) x 1 month: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), transcutaneous electrical nerve stimulation (TENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

Decision rationale: The Physician Reviewer's decision rationale: CA-MTUS (Effective July 18, 2009) page 114 to 116 of 127, section on TENS, chronic pain (transcutaneous electrical nerve stimulation) as not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. (Carroll-Cochrane, 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single-dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured. Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): - Documentation of pain of at least three months duration - There is evidence that other appropriate pain

modalities have been tried (including medication) and failed -A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial - Other ongoing pain treatment should also be documented during the trial period including medication usage - A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted - A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary The guideline stated a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration which was not documented in this patient.

Psychological Consult:

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment referral pg 398

Decision rationale: The Physician Reviewer's decision rationale: The patient sustained neck, head and back injury from an injury at work on 8/9/2013. Subsequent persistence of pains has been associated with increasing symptoms of anxiety, stress and insomnia. Guidelines contained in CA MTUS recommend psychological consultation for patients with or at risk for chronic pain. In addition, the ACOEM guidelines recommend referral for potential disorders which may be significant. The Official Disability Guidelines (ODG) for pain recommends psychological treatment for appropriately identified patients during treatment of chronic pain. The guidelines recommended identification of "patients who continue to experience pain and disability after the usual time of recovery. At this point, a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy." The ODG also states that, "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed." This patient meets ODG guidelines for psychological interventions. With the symptom picture presented, the criteria for referral for psychological evaluation been met and therefore the request for psychological consultation is medically necessary and appropriate.

LINT to the Thoracic and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), transcutaneous electrical nerve stimulation (TENS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Research and Treatment volume 2011, Article ID 152307.

Decision rationale: The Physician Reviewer's decision rationale: Electronic neurostimulation therapy could be efficacious in chronic neuropathic pain and other neurological diseases. Localized intense neurostimulation therapy is being investigated to determine effectiveness for the treatment of pain. As a form of imaging-guided hyperstimulation analgesia, some early indications suggest that the technique may yield promising results. The MTUS and standard guidelines are mute on this treatment modality and the documentation of evidence based efficacy is unavailable at this time. A recent study of the localized intense neurostimulation concluded that the decrease in pain and perceived disability, combined with the improvement in ROM, support further investigation of the use of this therapy in the treatment of LBP. The study was small, lacked a control group and may provide no more long term benefit than any treatment. In the absence of evidence of effectiveness, the requested LINT treatment is found to be neither appropriate nor medically necessary in this case

ESWT to the Thoracic and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), transcutaneous electrical nerve stimulation (TENS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin Number: 0649.

Decision rationale: ESWT is considered experimental and investigational for the treatment of thoracic and lumbar spine pain. The guidelines clearly do not support the use of this modality for treating the spine; therefore, ESWT to the Thoracic, Cervical and Lumbar Spine is not medically necessary. The Official Disability Guidelines specify that extracorporeal shockwave therapy (ESWT) is not recommended. High energy ESWT is not supported, but while low energy ESWT may show better outcomes without the need for anesthesia, it is not recommended either. Therefore, this use of ESWT is not medically necessary and appropriate.